RESEARCH INTO VIOLENT BEHAVIOR: OVERVIEW AND SEXUAL ASSAULTS

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
DOMESTIC AND INTERNATIONAL SCIENTIFIC
PLANNING, ANALYSIS AND COOPERATION
OF THE
COMMITTEE ON
SCIENCE AND TECHNOLOGY
U.S. HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION

JANUARY 10, 11, 12, 1978

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10 Psychological Treatment of Rapists

Gene G. Abel, Edward B. Blanchard, and Judith V. Becker

In recent years a variety of therapy techniques have been described for the treatment of rapists. These methods have been outlined in various publications, but there has been no attempt to organize the literature into a composite of the treatment components common to these programs. We will attempt such an organization as well as assess the evidence that supports the effectiveness of these treatment components.

Psychological evaluation and treatment of rapists has been impeded by both the lack of accessibility of rapists for evaluation-treatment and the failure of the psychological community to develop effective, efficient therapies for them. Accessibility of rapists for therapy has been, and continues to be, a major roadblock because traditionally rape has been viewed as a crime. The disposition of rapists has been through legal channels such as trials, prison, etc. Evidence that the criminal justice system has failed to convict most rapists is accumulating. For those convicted, recidivism rates have been relatively high.

The second major impediment to evaluation-treatment has been the failure of the psychological community to provide practical, effective treatment for rapists. In the last ten years, however, numerous new treatment methods have appeared for rapists, primarily based on treatments developed for the broad range of sexual deviates, such as voyeurs, exhibitionists, etc., who have been more accessible for treatment than rapists. With the guidance of methods developed for treating other sexual problems as well as a number of therapies already applied to rapists, a sufficient body of components for the treatment of rapists exists.

The Process of Psychotherapy Evaluation

There are differing levels of confidence or of validity of the evidence supporting the effectiveness of any particular treatment component. Some treatments have been extensively researched, relying heavily on the scientific method to confirm that the treatment is definitely effective. Other components have never been evaluated using the scientific method; and, although developed by competent clinicians, there is no scientific proof of their effectiveness. Understanding the

levels of scientific inquiry enables the reader not only to be aware of the components, but also to appreciate the extent of scientific proof indicating the effectiveness of the treatment.

Bergin and Strupp (Bergin and Strupp, 1972; Strupp and Bergin, 1969; Bergin, 1971) have outlined three levels of increasing sophistication in evaluating the effectiveness of any treatment intervention. These levels include case reports, controlled single-case experimental design, and controlled group outcome.

Case Reports

Most conclusions that a particular component of treatment for rapists is effective are based on clinical judgments derived from a therapist's experience. The therapist believes he or she is using a particular treatment strategy to produce behavior change. If the rapist improves, the therapist concludes it must have resulted from the therapy methods applied. However, since no experimental method is used and no dependent measures of progress are systematically collected, the rapist's improvement may have resulted for reasons completely unknown to the therapist. The confidence one can have in the validity of treatment effectiveness from such case reports is very low. Nonetheless, hunches derived from case reports are some of the best sources of treatment techniques to be investigated more thoroughly by using experimental methods.

Controlled, Single-case Experimental Design

A more sophisticated means of evaluating a treatment method involves planned, single-case experiments. The therapist first identifies dependent measures that he or she expects will be altered by the treatment. For a rapist, these measures might include the frequency of thoughts of rape and nonforced sexual intercourse, the subject's ongoing erection responses to rape and nonrape cues (Abel, Blanchard, and Mavissakalian, 1974; Abel, Barlow, Blanchard, and Guild, 1975), and his report of how arousing thoughts of rape and nonforced sexual intercourse are. After establishing the occurrence of these dependent measures in a rapist before treatment begins, the therapist then introduces, withdraws, and reintroduces a *single* treatment variable. If that treatment variable is effective, improvement as measured by the dependent variables will occur as the treatment is introduced, stop as it is withdrawn, and reappear as it is reinstated.

The single-case experiment is very powerful at identifying the effectiveness of one treatment method; however, it cannot compare the relative effectiveness of one treatment with another. A large number of treatments have been validated as effective with sexual deviants using this method, and a few treatment results have used this design with rapists, primarily pedophiliacs. (See Hersen and Barlow, in press, for a fuller description of single-case design procedures.)

Controlled Group Outcome

If a treatment method has been found to be effective by single-case experimental design, it is next compared to another treatment method by a controlled group outcome study. Two groups of rapists, for example, would be equated in all ways and dependent measures obtained before and after the treatment being investigated. One group would be administered the new treatment; the other would receive a standard treatment or no treatment at all. The relative improvement of the two groups provides the therapist with a valid measure of the effectiveness of the new treatment. Although this method has been used with mixed groups of sexual deviates including a few rapists, no group comparisons of any treatment have been reported using groups of rapists only. Group outcome studies only occur in the final stages of a therapy's development but yield the strongest, most valid results about a therapy.

The Treatment Components Common to Current Treatment Programs for Sexual Aggressives

Our review examines the current treatment programs for sexual aggressives. The first objective is to identify those treatment components common to a variety of programs, assuming that frequent use of the same component suggests that the technique is critical for the rapist's improvement. Our second objective is to identify the level of research supporting the effectiveness of that treatment component.

Empathic Relationship between Patient and Treatment Agent

Common to *all* programs is the establishment of a warm, accepting relationship between the offender and therapist. This relationship is especially critical in psychodynamically oriented treatments (Salzman, 1972; Karpman, 1954). The relationship (transference) becomes an essential vehicle by which the rapist's neurotic conflicts can be viewed, interpreted, and worked through to establish a more mature personality.

Pastoral counseling methods (Dates, 1972), milieu (Boozer, 1975a), and group therapy programs (Boozer, 1975b; Hendricks, 1975; MacDonald, 1974; Peters, Pedigo, Steg, and McKenna, 1968; Brancale, Vuocolo, and Prendergast, 1972) all stress the importance of the empathic relationship. Whether this relationship is established between patient and therapist or between patient and other offenders varies from program to program. Although behavioral modification programs tend to avoid discussions of the importance of this empathic

relationship, those behavioral programs that have been effective also establish a deep regard and empathy for the patient.

The precise mechanism by which this empathic relationship actually produces change is unclear. Group therapists stress as essential the value of the offender being accepted by other offenders in spite of his sexual offenses (Peters, Pedigo, Steg, and McKenna, 1968; Hendricks, 1975). Others stress the opportunity for the open expression of emotions during the therapeutic alliance as critical for the breaking down of unresolved psychological conflicts, especially issues around anger and hurt (outlined more thoroughly by Brancale, Vuocolo, and Prendergast, 1972). However, since no controlled research studies with rapists have systematically investigated the relationship of empathy to clinical improvement, the validity of the effectiveness of this factor is at the case report level.

Confrontation regarding the Responsibility for One's Sexual Behavior

It is difficult to separate the offender's denial of responsibility for his sexual acts, the confrontation methods used in treatment, and his understanding of the unconscious factors contributing to his rape behavior. Although the methods used vary widely from treatment program to treatment program, the goal of these techniques remains the same, i.e., that the offender accept the fact that *he* is responsible for his actions, that only he can stop his raping.

Pastoral counseling methods (for example, Oates, 1972) describe deviates' frequent attempts to justify their sexual offenses by considering "spiritual unity" or "mystical understanding" as a product of sexual misconduct and therefore not an appropriate behavior to change since the spiritual effects of the behavior would be lost. Some offenders use swift religious conversion as a testimony that they have changed the deviate behaviors. They attempt to avoid the issue of *how* they are going to prevent themselves from raping in the future, by attending instead to the strength of the religious insight and conversion. The pastoral counselor from the vantage point of an expert in religion not only must point out to the rapist the value of the rapist's religious convictions, but he must lead the rapist into specific therapeutic encounters with the treatment program to assist him in the specifics of how his urges to rape can be controlled.

Confrontation methods are more obvious in group therapy where denial, projection, and isolation are seen as early stages of therapy requiring confrontation between new patients and either the therapist or other offenders further along in the therapeutic process (Peters, Pedigo, Steg, and McKenna, 1968; Hendricks, 1975). The actual techniques of dealing with such resistance vary and may include such methods as marathon groups (Brancale, Vuocolo, and Prendergast, 1972), isolating the patient with other rapists so that he is more easily labeled as a rapist (Boozer, 1975a), sensitivity groups or video tape

feedback (Brancale, Vuocolo, and Prendergast, 1972), or verbal feedback from a variety of staff or other rapists (Hendricks, 1975).

Similar objectives are reached by more traditional psychoanalytically oriented psychotherapy (Karpman, 1954; Salzman, 1972). Confrontation per se is replaced by nondirective exploration of the patient's unconscious motivations that have led to rape behavior. The basic premise of such a method, however, is that known or unknown (unconscious) to the patient, rape behavior follows situations or conflicts that have been experienced by the rapist. It is, therefore, his responsibility to understand and change these factors and subsequently change his proclivity to rape.

Behavior modification approaches also require the patient to take responsibility for his behavior. All such methods that directly attempt to alter symptomatology require the rapist's cooperation in the treatment on both ethical grounds (without the patient's requesting treatment for his rape behavior, no treatment should be instituted) and for treatment reasons (all behavioral treatments require the active participation of the rapist and, therefore, acceptance of himself as having problems controlling his rape behavior).

As with the previous component, no systematic, controlled studies have investigated the importance of confrontation to therapeutic improvement. The level of confidence in the importance of this component is thus only at the case report level.

Heterosocial-Heterosexual Skills Training

Under this category falls a variety of methods for teaching social interaction between the rapists and others, especially the rapist and adult females. The premise of such skills training is that rapists may be sexually aroused by women, but unless they can carry out the preliminary conversation, flirting, and other dating skills antecedent to a relationship, they will not have the opportunity to become involved sexually with the female (except by rape).

In those treatment programs surveyed, the majority included social skills training at some level. Basic social skills, for example, are a major goal of most group therapy programs. The shy, withdrawn offender has the opportunity to learn to relate to others by observing and trying out new social behaviors while in the supportive surroundings of the therapeutic group (Peters, Pedigo, Steg, and McKenna, 1968; Boozer, 1975a, 1975b).

Many programs go a step further, however, in an attempt to teach offenders heterosocial-heterosexual skills. Pacht (Pacht, Halleck, and Ehrmann, 1962; Pacht, 1975) attempted to teach social interactions in prison by *requiring* that offenders actually ask for and "go out" on informal dates within the prison walls with females, e.g., secretaries, clerks, aides, etc. Two problems, however, interfered with such a program. Administratively, the security hospital where

treatment was initiated simply did not have sufficient numbers of females for the implementation of such a program. Furthermore, measures of the impact and effectiveness of such a program could not be obtained in the prison setting.

Pacht (1975) and MacDonald (1974) have both stressed the problems of implementing heterosocial skills training in the prison system. MacDonald has emphasized the countertherapeutic nature of our confinement system for sexual aggressives. Rapists, many of whom lack adequate heterosocial-heterosexual skills with women, are confined in security environments which actually isolate them from social contact with women. As a consequence, they have no opportunity to learn social skills and actually may become less adept with those skills they did have before incarceration due to lack of practice in prison.

Boozer (1975a), working with rapists within a state hospital, has also viewed heterosocial-heterosexual skills training as essential to treatment. She has hired *only female* attendants for her rapist treatment ward. Structured interactions between the rapists and the female staff are strongly encouraged. Boozer has also attempted to structure explicit sexual activity for the rapist. During the first year of hospitalization, no overt heterosexual behavior is allowed other than masturbation. During the second year, sexual behavior between the rapist and his wife is gradually reintroduced during weekend passes. Concomitant sexual counseling also occurs if problems are identified.

Sexual counseling in the form of sex education is also a component of the treatment programs at Atascadero State Hospital (Laws, 1974) and at the New Jersey Treatment Center (Brancale, Vuocolo, and Prendergast, 1974b), where offenders are acquainted with sexual information previously unknown to them.

Since the heterosocial-heterosexual skills training outlined above has never been separated from other components of treatment and since no controlled studies have been completed, the relevance and validity of such skills training for rapists is only at the case report level of confidence. Both controlled group outcome studies, however, have been conducted utilizing college students and psychiatric patients (non-sexual aggressives) as a subject population.

The problem of "minimal dating" among college males has recently been an area to which heterosocial skills training has been applied successfully. In these well-controlled studies, subjects have been non-psychiatric volunteer male college students (Martinson and Zerface, 1970; MacDonald, Lindquist, Kramer, McGrath, and Rhyme, 1973; McGovern, Arkowitz, and Gilmore, in press; Christensen, Anderson, and Arkowitz, in press; Christensen and Arkowitz, 1974). Goldsmith (1973) has also demonstrated the effectiveness of heterosocial skills training with psychiatric patients.

Hersen and Miller (1974), Eisler, Miller, Hersen, and Alford (in press), Hersen (1973), and Hersen, Eisler, and Miller (1973) have conducted a series of studies focused on the precise measurement of specific social skills deficits. Their results with nondeviant males suggest that treatment must focus on three response systems: (1) verbal and nonverbal (motor behavior) communication, (2) physiological concomitants (not feeling discomfort, e.g., anxiety in a social situation),

and (3) the patient's attitudes and verbal reports on how he feels in the various stages of treatment or social situations.

The present authors conducted a series of studies to develop a systematic approach to the teaching of heterosocial-heterosexual skills. During these studies, it became apparent that minimal attention had been given to what behaviors actually reflected poor social skills and, therefore, what behaviors needed to be taught. We subsequently videotaped and observed the heterosocial skills displayed by sexual deviates who had indicated they historically had difficulty dating and clinically appeared to lack social skills. Their talking with a female assistant (as if trying to ask for a date) was compared with the performance of males of a similar age who were identified by their female friends as being very adept at heterosocial skills.

It became apparent that specific motor skills, the amount of affect displayed, components of voice, and flow of conversation clearly discriminated between the two groups, and a heterosocial scale was developed (Barlow, Abel, Blanchard, and Bristow, 1975). This scale can be used to assess any rapist's heterosocial skills with women. When the patient reports heterosocial skills deficits and these are confirmed by measurement with the heterosocial skills scale, treatment is initiated to correct the deficits.

Treatment, substantiated by single-case experimental design methods, begins by establishing the rapist's baseline skills performance. Thirty-minute treatment sessions involve videotaping the rapist's social performance. One element of the skills scale is corrected at a time, by verbal feedback as to how the rapist should change, by modeling correct behavior for him, by verbal reinforcement for improved performance, and by videotape feedback that allows him to see not only his deficits, but also his improved skills.

The most impressive aspects of such treatment are the lack of heterosocial skills displayed by some rapists and the rapidity with which the patients can acquire these skills with direct skills training (usually within two to three weeks). The current state of assessing the utility of this treatment component is as follows: numerous single-case and controlled outcome studies have demonstrated its effectiveness with nondeviants; controlled single-subject studies have recently been conducted with sexual deviates, but no controlled studies have been completed with rapists. Now that adequate dependent measures of social skills acquisition have been established, controlled studies are expected to accelerate. For the present, case reports strongly support the need for heterosocial-heterosexual skills, and single-case experiments have confirmed the effectiveness of skills training.

Increasing Arousal to Adult Females

Surprisingly, a number of sexual aggressives show little or no sexual arousal to adult females and/or to "normal" sexual intercourse with a consenting adult.

This may sound paradoxical at first, since most rapists are arrested for sexually forcing themselves on adult females. Many rapists, however, report that intercourse with a consenting female is not erotic. Forced sexual contact or actually sadistically raping the female, by contrast, is highly erotic.

These reports by rapists have recently been confirmed experimentally in the laboratory (Abel, Barlow, Blanchard, and Guild, 1975). Thirteen rapists and seven controls were presented rape or mutually enjoyable intercourse scenes while monitoring subjects' erections. Results indicated that only those subjects with histories of rape responded significantly to the rape scenes. Furthermore, when rapists were arranged along a continuum from few to many rapes, those with the highest incidence of rapes had very high arousal to rape scenes but relatively low arousal to mutually enjoyable intercourse scenes.

Other rapists fail to respond to mutually enjoyable intercourse with an adult female because they are exclusive pedophiliacs. Regardless of why a rapist fails to have adequate arousal to adult women, the psychoanalytic psychotherapy programs and behavior modification programs both have viewed development of such arousal as a critical element of treatment, a component ignored by other treatment programs.

Analytically oriented therapists such as Rado (1949), Karpman (1954), Ovesey, Gaylin, and Hendin (1963), Bieber, Bieber, Dain, Dince, Drelich, Grundlach, Kramer, Wilber and Bieber (1963), and Salzman (1972) have viewed heterosexual fear and avoidance as the underlying causes of sexual deviations such as rape. Treatment has involved exploration of the rapist's fears and phobias of women or female genitalia (castration anxiety) so as to allow genital union between the patient and a mutually consenting adult female. Since rape is viewed as an avoidance behavior that has replaced such consenting sexual union, it is assumed that once such adult genital union is completed, rape will no longer be necessary.

Although this conceptual model is used by the analytically oriented programs and is felt to be critical for treatment, no measures concomitant with analytic treatment have been obtained to substantiate that resolution of castration fears leads to increased arousal to adult females and to reduction of arousal to rape cues. Controlled studies are still needed in this area.

By contrast, behavioral programs have developed several methods of increasing normal heterosexual arousal as substantiated by well-controlled studies that have recorded the patient's increased erection to adult females as treatment progressed. The methods include masturbatory conditioning, fading, classical conditioning, and exposure, and have recently been summarized and reviewed by Abel and Blanchard (in press).

Of particular relevance to the treatment of sexual aggressives are the techniques of masturbatory conditioning (Abel and Blanchard, 1974) and fading. In the former technique the patient is taught to substitute normal heterosexual fantasies in place of his sexually aggressive fantasies used during

masturbation. Marshall and his colleagues (Marshall, 1973; Marshall and Williams, 1975) have successfully used masturbatory conditioning as part of their treatment program for rapists and pedophiliacs. Abel and his associates (Abel, Barlow, and Blanchard, 1973; Abel, Blanchard, Barlow, and Flanagan, 1975) have used masturbatory conditioning as the exclusive treatment modality in two single-subject experiments with sadistic sexual aggressives. In these latter studies, not only did the sadistic aggressives develop arousal to mutually enjoyable intercourse cues, but concomitantly they both lost their marked arousal to sadistic cues without institution of a treatment method specifically to reduce that sadistic arousal. We have observed similar results in about one-third of those patients who once lacked, but later developed, normal heterosexual arousal. This finding points to the value of developing adequate heterosexual arousal before decreasing arousal to rape, since arousal to rape cues may simply extinguish while heterosexual arousal develops. It also stresses the need for continuous monitoring of arousal patterns throughout treatment so as to identify which treatments are actually needed (Barlow and Abel, in press).

Another promising behavioral method for developing heterosexual arousal is fading (Barlow and Agras, 1973). Based on the stimulus control literature, the method involves gradually changing the source of the patient's erection response from a deviant object (arousal to young children, for example) to a nondeviant object (an adult woman). Laws (1974a) has recently automated this procedure with some degree of success.

In conclusion, the behavior modification approaches have developed a number of methods to generate arousal to consenting adult females in rapists previously lacking such responses. Although no controlled outcome studies have been completed, numerous single-subject experiments have confirmed the effectiveness of these treatment methods.

Decreasing Sexual Arousal to Rape

This final component of treatment involves techniques to decrease the rapist's sexual arousal to thoughts and urges to rape. Reducing rape behavior is an objective of all treatment programs, although some programs have more explicit methods to accomplish this than others.

Psychoanalytically oriented treatment programs (Salzman, 1972) do not necessarily see reduction of urges to rape as the major goal of treatment since rape is viewed as but one expression of the patient's basic personality. Treatment is not aimed primarily at this symptom reduction (arousal to rape), but ideally involves resolution of the patient's castration anxiety and heterosexual phobia. Control of rape behavior is expected to follow reestablishment of his sense of self-worth.

Individual and group therapy programs attempt to improve the patient's

self-control of his urges to rape by repeated confrontation, catharsis, testimonials, and numerous self-control methods.

Another method to reduce arousal to rape has been to reduce overall sexual drive by either surgical or chemical castration. Surgical castration has been completed in over 900 cases of sex offenders at the Herstedvester facility in Denmark (Stürup, 1968). Of 38 rapists housed at that unit from 1935 to 1961, 18 requested and were granted surgical castration. Information has been reported for 11 of these cases released one year after castration. Of these 11, no rapist has been rearrested for a sexual crime, but 6 of the 11 were arrested for non-sexually related crimes.

A form of reversible castration, the use of the drugs cyproterone acetate or medroxyprogesterone, has been more recently explored (Hoffet, 1968; Laschet, Laschet, Fetzner, Glaesel, Malland and Naab, 1967; Money, 1970). These agents functionally cause a depletion of testosterone which results in a decline in sexual drive and interest and reportedly with greater control over one's sexual behavior. These agents also produce side effects such as impotence and depression. This treatment has generally been used in a crisis situation, when the patient reports loss of control is eminent, and there is need for some immediate control of his desire to rape. Clinically, it appears that the acute reduction of overall sexual drive may be of therapeutic value in some cases, but the ultimate and more humane goal of treatment should be *selective* reduction of deviant arousal while nondeviant arousal is maintained. To date, such discrimination of arousal has not resulted from chemical castration.

The opportunity for ethical abuse using castration methods is fairly high, especially in view of the permanency of surgical castration. Of equal concern are the effects of castration on other treatment program development. If castration was seen as an easy method to reduce sexual arousal to rape, fewer programs might be researched to teach suppression of arousal to rape cues while maintaining arousal to normal heterosexual themes.

Behavior modification approaches to the treatment of sexual deviates initially focused almost exclusively on methods for decreasing excessive sexual arousal to deviant persons, objects, or activities. Hence, there is a fairly large body of literature on the use of aversion therapy with a variety of sexual deviates (summarized in Rachman and Teasdale, 1969; Barlow, 1972). Studies at all levels of sophistication, from case reports to controlled group outcome studies, have been completed with sexual deviates generally, although only case reports and single-subject experiments exist for rapists specifically.

Behavioral aversion methods do not vary theoretically from other therapies, in which thoughts of rape are associated with discussions of aversive consequences. They do vary in three significant areas however. First, behavior approaches use a greater variety of aversive stimuli to pair with rape cues. Second, these pairings occur over time, and the association between rape and aversive cues becomes more easily learned. Finally, as exemplified in prior

sections, dependent measures are recorded during treatment to substantiate that with aversion, arousal (erection) to rape cues decrease while arousal to nonrape heterosexual cues continues (Abel, Levis, and Clancy, 1970).

Any variety of aversive cues such as offensive odors, pain delivered by electrical shock to the arm, or aversive images (such as fantasies of being arrested or shot in the process of attempted rape) may be used in such treatment. A variety of researchers (Abel, Levis, and Clancy, 1970; Marshall, 1973; Marshall and McKnight, 1975; Abel, Abel, Blanchard, Barlow, and Flanagan, 1975; Marshall and Williams, 1975) have reported electrical aversion as being successful at suppressing arousal to rape cues with adult rapists or pedophiliacs. This effectiveness has been confirmed by case reports and single-subject experiments.

Another aversive technique, covert sensitization (Cautela, 1967), has recently been shown to be as effective as electrical aversion (Callahan and Leitenberg, 1973). Covert sensitization has the added advantages of being less susceptible to ethical abuse and of requiring less equipment. The rapist is asked to imagine those situations that are most conducive to rape, including the circumstances preceding the act, the environment, the victim, her response, etc. Once these scenes are well in the patient's "mind's eye," aversive scenes such as being shot by the police, being beaten in jail after an arrest, are interspersed. Such pairings are repeated, and the rapist learns to use similar aversive scenes any time urges to rape are high. We have recently completed two single-subject experiments using covert sensitization. Its effectiveness has been confirmed by the rapists' markedly reduced erections to rape cues and by their verbal reports of decreased urges to rape.

Treatment Results

The process of psychotherapy evaluation and a review of the components of effective treatment for rapists indicate that evaluating total treatment outcome is premature. At this time, the elements of total treatment for the rapist are still being developed. Although attempts have been made to define the total treatment needs of sexual deviates in general (Barlow and Abel, in press), studies evaluating treatment for rapists have relied primarily on recidivism rates. Even comparing the effectiveness of programs using the simple measure of recidivism (in effect, reduction of arousal to rape cues) is filled with complications. For example, some centers report their treatment results with all types of sexual deviates, while other centers report treatment with rapists only. Unequal amounts of treatment are applied by different centers, making comparison difficult. Recidivism itself is frequently determined differently: some centers rely on rearrest, some rearrest for sexual crimes, some rehospitalization, etc. Finally, some centers have a limited follow-up period, while others carry out extensive follow-up for five years or more. In spite of these limitations, the

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following table summarizes the results from some of the treatment programs. (See Table 10-1.)

Of special note are the data from the Atascadero State Hospital. This information was obtained from patients discharged from 1954 to 1960 and involved the most detailed comprehensive follow-up available so far. Although the data do not represent the effectiveness of newer treatment methods initiated at Atascadero, they do suggest a relatively high recidivism rate (22 to 36 percent) five years following discharge from what was essentially a milieu and group therapy program at that time. Since other programs report recidivism rates ranging from 0 to 9 percent, such low rates may simply reflect briefer, less thorough follow-up periods. It is clear from the available publications that, except for the data from Atascadero, no treatment program has sufficiently developed a follow-up system to allow an adequate appraisal of treatment results at this time.

Experience from our own treatment program suggests that at the present, it is impossible to compare treatment results across programs. We are only beginning to define which components of treatment are needed and what objective measures confirm the effectiveness of a treatment method to alter that component. We find each rapist has a specific combination of treatment needs, requiring treatment of one, two, three, four, or all five of the components outlined above. Until group outcome studies comparing identical groups of rapists with identical components of treatment needs are completed, a comparison of results from treatment centers is only suggestive of their relative effectiveness.

The important point at this time is that the first step toward scientific inquiry—the development of objective measures of treatment progress—has been made. More single-case and controlled outcome studies will follow. In the meantime, perhaps our communities' attitudes toward the sexual aggressive will allow further application of newer treatment methods, rather than relying on the current incarceration techniques that have hindered the development of treatment methods for so long.

Table 10-1
Treatment Center Outcomes for Sexual Aggressives

Program	Treatment Population	Outcome
Atascadero State Hospital, Atascadero, California	106 sexual aggressives with adult or child victims	22 percent recidivism rate at 5-year follow-up for pedophiliacs, 36 percent for adult rapists
Center for the Diagnosis and Treatment of Dangerous Persons, Bridgewater, Massachusetts	82 physical or sexual aggressives	6 percent later committed assaultive crime
Herstedvester Center, Denmark	11 rapists	No recidivism for sex crimes at 11-year follow-up
New Jersey State Diagnostic Center, Menlo Park, Edison, New Jersey	200 sexual deviates, 29 percent of which were rapists	"Very small" recidivism
Philadelphia General Hospital, Philadelphia, Pennsylvania	92 sexual deviates, some of which were rapists	1 percent arrests for sex crimes at 2-year follow up
South Florida State Hospital, Coral Gables, Florida	75 rapists	7 percent recidivism at unspecified follow-up
Western State Hospital, Ft. Steilacoom, Washington	658 sexual deviates, 11 percent of which were rapists	9 percent rehospitalization rate at unspecified follow-up
Wisconsin Sex Offender	475 sexual deviates, some of which were rapists	9 percent recidivism at unspecified follow-up

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